Community Kids Health Requirements

Child's Name:____

Admission requirement: One of the following must be presented when your child is admitted into this facility.

____Doctor's statement: I have examined within the past year and find that he/she is physically able to take part in the Community Kids program. This form may be faxed to our offices at 936-271-4446.

____ ___________________

Physician's Signature Date

_____A copy of the medical screening from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program if not a referral for further diagnosis and treatment indicated.

____ A form or written statement from health service or clinic.

Name and address of physician OR address of EPSDT screening site:

____

Name Street City State Zip

_____My child has an appointment for a physical examination:

Date:_______________

_____ Parent's statement: I will submit physician's statement, EPSDT form, health service or clinic form to the facility following examination.

Authorization for emergency medical attention:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Name of Physician:___________________________ Phone:______________________

Address:____

Name of hospital:____________________________ Phone:_______________________

Address:____

You must have the following records at enrollment:

~Up to date copy of immunization records

~Proof of hearing and vision screening for children four and five years old.

Parent Signature____ Date _____________